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ABSTRACT

Recognizing that each student is different in terms of communication apprehension and needed skills, the confidence model attempts to provide instruction in anxiety reduction and skill development, combining the features of both the behavior therapy and the rhetoritherapy theories of communication apprehension. The rational emotive therapy used in the confidence program emphasizes the importance of the effects of thoughts on behaviors and feelings. This therapy appears to be highly effective with subjects who report more generalized, cross-situational speech anxiety, while systematic desensitization appears to be primarily effective with subjects for whom speech anxiety is confined to formal speaking situations. After students are screened by interviews and self-report inventories, they describe their perception of particular oral communication needs in a conference, and the teacher and student then plan communication goals. During the course, the student has the choice of the number and type of speech activities to be accomplished and determines the amount of progress and the semester grade he or she wishes to pursue. The course begins with a discussion of the variables affecting oral communication and is then divided into six parts: (1) rational thinking, (2) goal setting, (3) social conversation, (4) interviewing, (5) group discussion, and (6) public speaking. For both alleviating speech anxiety and developing oral communication skills, the confidence model appears to be an excellent alternative to college basic speech courses. (HTH)

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The Confidence Model: An Alternative Approach to Alleviating Communication Apprehension

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The Confidence Model: An Alternative Approach to Alleviating Communication Apprehension

Communication apprehension, also termed speech anxiety or speech reticence, has been identified as America's number one fear (Bruskin, 1973). It is prevalent in public school settings (Bashore, 1971, Hurt, Preiss, and Davis, 1976), affects twenty percent of college speech populations (McCroskey, 1972), and is manifested in working adults (McCroskey and Richmond, 1979) and senior citizens (Moore, 1972). Its influence impacts on student achievement (McCroskey and Andersen, 1976), classroom seating preference (McCroskey and McVetta, 1978), preferred instructional strategies and settings (Scott, Yates, and Wheeless, 1975), teacher expectancies (McCroskey and Daly, 1976), and student attitudes toward school (McCroskey and Sheahan, 1978). Communication apprehension not only touches academic achievement, but it appears to affect other areas of life such as communication (avoidance) techniques (McCroskey, 1977), amount of self-disclosure (Hamilton, 1972, Wheeless, Nesser, and McCroskey, 1976), occupational choice (Daly and McCroskey, 1975) and selection of housing locations (McCroskey and Leppard, 1975).

Because of the pervasive effects of communication apprehension, considerable effort has been expended to identify ways to alleviate it. The Confidence model reviewed here attempts to combine the strengths of two major theories of alleviation, that of McCroskey (1972), the need to overcome speech anxiety, and that of Phillips (1968), the need to develop speech skills. Generally the Confidence model shows that by combining these two perspectives, that is having a treatment to alleviate speech anxiety while learning fundamentals of speech, the speech apprehensive student can make significant improvements in his or her attitude toward self, environment, and the skills of oral communication. This report describes the rationale and methodology for the Confidence model.

RATIONALE

Two major schools of thought exist concerning alleviation of communication apprehension and reticence (Page, 1980). The first is the communication-anxiety behavior therapy school advanced by McCroskey and colleagues (McCroskey, 1977). They regard excessive anxiety to be a major, if not the primary, cause of communication apprehension. The second school, developed by Gerald Phillips and associates and known as the speech-rhetoritherapy school, omits reference to anxiety and dwells on the dysfunction of one or more rhetorical processes (Phillips and Solokoff, 1979).

Primary tenents of the communication anxiety-behavior therapy school specify anxiety as being a learned response which can therefore be unlearned and this anxiety may cause an individual to be less effective when approaching and during communication activities. Speech communication teachers may adequately learn and teach behavior therapy methods to reduce speech anxiety (Page, 1980). Major

methods of this school include systematic desensitization (McCroskey, Ralph, and Barrick, 1970), rational emotive therapy (Ellis, 1962, Meichenbaum, Gilmore, and Fedoravicius, 1971, Karst and Trexler, 1970), and cognitive modification, (Fremouw and Scott, 1979).

Conversely, the speech-reticent rhetoritherapy school advances the notion that anxiety is not the basis of dysfunctional communication, contending that anxiety is the basis for dysfunction presumes a medical model rather than an instructional one as favored by Phillips. Even supposing anxiety were the basis of the problem, it would be inappropriate to eliminate anxiety totally since (a) minimal anxiety provides minimal motivation and (b) treatment of severe anxiety falls in the province of psychiatry. Therefore advocates of this school suggest that communication teachers should implement rhetoritherapy programs to treat dysfunctional communication rather than programs to alleviate anxiety (Phillips, 1977 Page, 1980). Rhetoritherapy, or skills development, includes a description of the behavior of the student and how others respond to him or her, setting of communication goals, and development of related speech skills training (Phillips and Metzger, 1973, Phillips, 1977).

Research reports show that both schools have advanced acceptable arguments in support of their theories. Perhaps the difference between the two schools lies in which treatment procedures are the most effective with particular individuals. Glaser (1981) concludes:

> "Systematic desensitization or cognitive therapy might be the most appropriate treatment for those people who are assessed to have the requisite skills but who avoid oral communication because of excessive anxiety or negative self-verbalizations. Skills training, on the other hand, would be the treatment of choice for persons whose social behavior is deficient. There are likely to be a large number of individuals for whom some combination of the three treatments would be the most successful."

Page (1978) reports studies which combine approaches. Both therapy (anxiety reduction) and intensified speech training show promise as a combined treatment package that may supercede the effectiveness of either approach alone. Moreover, a number of studies have concluded that while systematic desensitization and cognitive modification may improve subjects' self-report measures of interpersonal anxiety, only skills training appears to produce concomitant change in actual communication behavior (Glaser, 1981). Curran (1977) for example, found skills training to be successful in increasing performance and decreasing anxiety.

Recognizing that each student is different in terms of apprehension and needed skills, the Confidence program attempts to provide instruction in anxiety reduction and skills development. Cognitive therapy, more specifically rational emotive therapy, the anxiety treatment used in the Confidence program, emphasizes the importance of the effects of thoughts, or cognitions on behaviors and feelings.

Cognitive therapy appears to be highly effective with subjects who report more generalized, cross-situational speech anxiety (Meichenbaum, et al., 1971) while systematic desensitization appears to be primarily effective with subjects for whom speech anxiety is confined to formal speaking situations (Fremouw and Zitter, 1978). The Confidence program also incorporates goal setting, a component of the rhetoritherapy method, which involves changing general and idealistic goals into specific descriptions of actions to be performed. Thus, in the Confidence model the student experiences in vivo desensitization by imagining the desired communication activity then performs and practices the behavior desired. Skills training is accomplished through the development and practice of social conversation, interviewing, group discussion, and public speaking. The Confidence model, therefore combines the positive features advocated by the anxiety reduction behavior therapy and rhetoritherapy schools in the alleviation of communication apprehension.

PROCEDURE

After students are screened by interviews and self-report inventories and invited into the Confidence class, a conference is scheduled wherein the student describes his or her perception of particular oral communication needs. The student and teacher then plan communication goals. During the course, the student has the choice of the number and type of speech activities to be accomplished and to determine the amount of progress and the semester grade he or she wishes to pursue. A mid-term and final evaluation assess the student's progress in understanding concepts and development of pertinent communication skills. At the end of the semester, a second conference is held to review activities, evaluations, number of absences, etc., in an effort to ascertain the student's grade.

After the first round of student-teacher conferences, the course begins with a discussion of the variables which affect oral communication skills, including various theories of speech apprehension and suggested causes of the lack of the development of oral skills, relevant research, and the importance of self-acceptance to communication performance. The course is then divided into six parts: (1) rational thinking, (2) goal setting, (3) the skills of social conversation, (4) interviewing, (5) group discussion, and (6) public speaking. In an initial effort to come to grips with and manage anxiety, instruction in rational thinking explains that what and how individuals think largely determines the emotions they experience and what they are likely to do (Ellis and Harper, 1975, Maultsby, 1970). Rational thinking is based on determining objective reality and shows ways to achieve life goals more efficiently while helping one to avoid emotional conflict with self and others. Activities for understanding and practicing rational thinking include a method of managing and controlling irrational beliefs and a procedure for deciding when ideas are rational and irrational. Thus, by learning a method of managing emotions, including anxiety, the student is encouraged to develop confidence in his or her abilities.

Part two of the confidence program shows the student how to identify needed

oral communication goals. Thereafter the student learns to describe desired outcomes of the goals and recognize when the goal is achieved. Examples of goals for social conversation, group discussion, and public speaking are examined and students use standard goal setting forms to plan and accomplish communication activities (Metzger, 1974, Kibler, Barker, and Cegals, 1970).

Part three begins specific instruction and the practice of oral communication skills. Students are introduced to the underlying purposes and techniques of social conversation, the dynamics which produce success, and the impact of the participants' personality on communication outcomes. Models are drawn from successful communicators such as Barbara Walters, Dorothy Sarnoff, and Phillip Zimbardo. Conversation topics are explored and role-playing activities practiced for a diversity of social occasions.

Building upon the skills developed in social conversation, part four deals with the dyadic interview in social, informational and business settings. The student is introduced to the definition, purposes and categories of interviewing as well as the process of questioning and the conditions required for successful interviewing. Students distinguish types of questions, develop a format for the dyadic interview, and participate in a learning package directed toward the employment interview.

Additional communication skills are explored in part five, group discussion, wherein students become involved in problem solving techniques and democratic decision making. A problem is defined and analyzed, and after investigation, solutions are developed, agreed upon, and reported to the class.

Part six of the Confidence program is devoted to mastering extemporaneous speaking. The student is reminded of ways to manage emotions, accomplish goals, and is encouraged to use these insights and the techniques for managing anxiety as motivational sources to help enliven speeches. Skill development includes how to determine and hold audience attention and methods of organizing and outlining speeches. Then, by examining the use of language, techniques of delivery, and visual aid usage, the student learns to deliver speeches.

CONCLUSION

For both alleviating speech anxiety and development of oral communication skills, the Confidence model appears to be a viable alternative to the usual basic speech course for those college students who experience above average communication apprehension. Continuing data at Western Kentucky University suggests significant improvement in self-report inventories and case study reports for apprehensive students, moreover during two one-semester terms, every participating apprehensive student in three sections improved their self-report inventory scores to below the hypothetical mean. Moreover, data concerned with self-esteem testifies to the appropriate use of rational thinking for alleviating speech anxiety along with building personal confidence, and suggests significant improvement in self-esttem for apprehensives as compared with students in regular basic speech classes. The Confidence model purposefully developed by a speech communication educator for use in the speech classroom may be successfully taught and managed by other speech educators.

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